California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814
Phone (916) 445-5014
Fax (916) 327-6308

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

EXEMPTION CERTIFICATE APPLICATION AND REQUIREMENTS

An exemptee is an individual who performs clerical, inventory control, housekeeping, delivery, maintenance, or similar functions related to the distribution or dispensing of dangerous drugs or dangerous devices. To work as an exemptee in California, you must possess and keep a current certificate as an exemptee.

It takes approximately six weeks to issue an exemption certificate after submission of a complete and acceptable application package. The board will notify you if additional information is needed to process your application package.

Effective January 1, 2002, an applicant for certification as an exemptee must be a high school graduate or possess a general education development (GED) equivalent **AND** meet all of the qualification methods described below. If you were certified as an exemptee in the past and are reapplying, you must meet the educational requirements as well as the experience and training requirements, unless you meet all of the prerequisites to take the examination requirements for licensure as a pharmacist by the board.

HOW TO APPLY TO BECOME AN EXEMPTEE

Your application must include:

- A non-refundable application fee of $75.00
- A complete Exemption Certificate Application (17A-E), with all questions answered. You must sign this form and attach a photograph.
- A completed Exemptee Experience Declaration (17A-E2)
- A completed Exemptee Training Declaration (17A-E3)
- A copy of Request for Live Scan Service Form verifying that your fingerprints have been scanned and all applicable fees paid. (See instructions below under “fingerprint requirements.”)
- If you would like notification that the board has received your application, please submit a stamped postcard addressed to yourself.

EXEMPTEE CERTIFICATION REQUIREMENTS

An individual applying for an exemption certification shall meet the following requirements:

Be a high school graduate or possess a general education development equivalent,

Have a minimum of one year of paid work experience related to the distribution or dispensing of dangerous drugs or dangerous devices **or** meet all of the prerequisites to take the examination required for licensure as a pharmacist by the board, and

Complete a training program approved by the board that, at a minimum, addresses each of the following subjects:

(A) Knowledge and understanding of state and federal law relating to the distribution of dangerous drugs and dangerous devices.
(B) Knowledge and understanding of state and federal law relating to the distribution of controlled substances.
(C) Knowledge and understanding of quality control systems.
(D) Knowledge and understanding of the United States Pharmacopoeia standards relating to the safe storage and handling of drugs.
(E) Knowledge and understanding of prescription terminology, abbreviations, dosages and format.

You must provide proof of completion of the required training to the board by completing and submitting the enclosed Exemptee Training Declaration form (17A-e3)

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at http://caag.state.ca.us/app/contact.pdf or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of $42 ($32 California Department of Justice (DOJ) processing fee and $10 DOJ expedite fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

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APPLICATION FOR AN EXEMPTION CERTIFICATE

Print or type

Name: Last	First	Middle	Former	TAPE A PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION **NO POLAROID**
*Address of record: Number	Street			
City	State	Zip Code		
Residence Address: (if different from above) Number	Street			
City	State	Zip Code		

Home telephone number	Work telephone number	Date of Birth	Social Security Number **
( )	( )		

Have you previously applied for certification with the board as an exemptee? Yes ☐ No ☐
If "yes," provide the date you applied:_____ Name applied under: _____

Have you previously been **certified** as an exemptee? Yes ☐ No ☐

EDUCATION

Name of high school attended _____Location of school (city & state) _____

Graduate from high school Yes ___ Date: _____ GED ___ Date: _____

Name that appears on diploma or GED certificate _____

TRAINING RECEIVED TO MEET EXEMPTEE QUALIFICATIONS (Must be Completed)

Name and address	Date of completion/graduation	Degree/Name of course

PHARMACIST EXAM

Are you eligible to take the California pharmacist licensure exam? Yes ☐ No ☐

If "yes," provide the date you applied:_____ Name applied under: _____

DO NOT WRITE BELOW THIS LINE

Live Scan ☐
Photo ☐
Exp Aff ☐
FP Clearance ☐

Training cert ☐
Hours verified_____

Certification No. _____
Date Issued _____

Application fee no. _____
Amount _____
Date Cashiered _____

* Once you are licensed with the board the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 et seq.) and the Public Records Act (Government Code section 6250 et seq.) and will be placed on the Internet upon licensure. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is a box number you must also provide your residence address as an alternate address that will not be available to the public.

EXEMPTEE EXPERIENCE –List all qualifying experience earned in and out of state performing the tasks of an exemptee. If you have been certified previously as an exemptee in California, provide your exemption certificate number and list experience earned as an exemptee in California. Please attach additional sheets if necessary **(Must Complete One or Both Sections)**.

California exemption certificate number _____ Expiration date _____

Dates of employment		Name and address of employer(s)	Total hours experience	Name of person having direct knowledge of your experience
From	To			

EXPERIENCE – List all qualifying experience earned in and out of state.

Dates		Name and address of employer(s)	Total hours experience	Name of person having direct knowledge of your experience
From	To			

California law requires completion of a training program that includes:

- State and federal laws regarding the distribution of dangerous drugs and dangerous devices
- State and federal laws regarding the distribution of controlled drugs
- United States Pharmacopoeia standards for the safe storage and handling of drugs
- Knowledge of quality control systems
- Prescription terminology, abbreviations, dosages and format

You must provide a written explanation for all affirmative answers. Failure to do so may result in this application being deemed incomplete.

1. Do you currently engage, or have you been engaged in the past two years, in the illegal use of controlled substances? Yes ☐ No ☐

   If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **Attach a statement of explanation**.

2. Has disciplinary action ever been taken against your pharmacist license, intern permit or exemption certificate in this state or any other state? **If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes ☐ No ☐

3. Have you ever had an application for a pharmacist license, intern permit or exemption certificate denied in this state or any other state? **If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes ☐ No ☐

4. Have you ever had a pharmacy permit, or any professional or vocational license, certification or registration denied or disciplined by a governmental authority in this state or any other state? **If "yes," provide the name of company, type of permit, type of action, year of action and state.** Yes ☐ No ☐

5. Have you ever been convicted of or pled no contest to a violation of any law of a foreign country, the United States or any state laws or local ordinances? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside under Penal Code sections 1000 or 1203.4. Traffic violations of $500 or less need not be reported. **If "yes," attach an explanation including the type of violation, the date, circumstances, location and the complete penalty received.** Yes ☐ No ☐

6. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, or any other entity licensed in this state or any other state? If yes, provide company name, type of permit, permit number and state where licensed. Yes ☐ No ☐

7. Do you have, or have you had in the last 5 years, any direct or indirect beneficial interest in any other premises licensed by the Board of Pharmacy? Yes ☐ No ☐

8. Have you ever been in violation of any provisions of pharmacy law? Yes ☐ No ☐

9. Are you currently or have you previously been associated in business with any person, partnership, corporation or other entity, or shared a financial or community property interest with any person whose permit or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state by a federal regulatory agency? Yes ☐ No ☐

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

_____ _____

Signature of applicant (in full—no initials) Date signed

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USCA 405(c)(2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code. If you fail to disclose your social security number, your application for license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

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Exemptee Experience Declaration

TO BE COMPLETED BY APPLICANT (please print or type)

Name of Applicant			Residence Telephone Number ( )
Residence Address Number and Street	City	State	Zip Code

To be completed by the person having direct knowledge of applicant's experience

(Please print or type. Check one box)

_____ was employed for at least one year of paid experience
(Name of Applicant)

performing the duties relating to the dispensing or distributing of dangerous drugs and devices in a:
☐ wholesaler; ☐ veterinary food-animal drug retailer; ☐ FDA licensed manufacturer; or
☐ other _____ (Specify location)

from _____ to _____ Number of years _____
(month/day/year) (month/day/year)

DO NOT state "current, present or still employed" (use exact dates)

Name and Address of Declarant/Employer

Name of declarant/other		Business License Number	
Address Number and Street	City	State	Zip Code
Name of Person Having Direct Knowledge (please print)	Board of Pharmacy License #	Telephone Number	

I declare under penalty of perjury under the laws of the State of California that all statements given herein are true and correct.

_____ _____
Signature of Person Having Direct Knowledge of Applicant's Work Experience — Position — Date

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Exemptee Training Declaration

TO BE COMPLETED BY APPLICANT (please print or type)

Name of Applicant			Residence Telephone Number ( )	
Residence Address Number and Street		City	State	Zip Code

To be completed by the person having direct knowledge of applicant's training

(Please print or type. Check one box)

The individual applying for certification as an exemptee in California has completed training required by Section 4053 of the California Business and Professions Code that addresses, at a minimum:

☐ Knowledge and understanding of state and federal laws regarding the distribution of dangerous drugs and dangerous devices;

☐ Knowledge and understanding of state and federal laws regarding the distribution of controlled substances;

☐ Knowledge and understanding of United States Pharmacopoeia standards for the safe storage and handling of drugs;

☐ Knowledge and understanding of quality control systems; and

☐ Knowledge and understanding of prescription terminology, abbreviations, dosages and format.

This training was provided by _____
(Name of company, school or individual providing the training)

From _____ to _____ Number of years _____
(month/day/year) (month/day/year)

DO NOT state "current, present or still employed" (use exact dates)

Name and Address

Name of Person Having Direct Knowledge of Training	Address	City	State	Zip Code
Business/School Name or Training Provider		Telephone		

I declare under penalty of perjury under the laws of the State of California that all statements given herein are true and correct.

_____ _____
Signature of Person Having Direct Knowledge of Applicant's Training Position Date

INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://caag.state.ca.us/app/contact.pdf or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of $32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Wholesaler - Section 4305.5

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

ORIGINAL **-Live Scan Operator; SECOND COPY-Board of Pharmacy; THIRD COPY-Applicant**

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

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Job Title or Type of License, Certification or Permit: Pharmacy Wholesaler - Section 4305.5

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400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento CA 95814
City State Zip Code

(916) 916-445-5014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

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Contact Name (Mandatory for all school submissions)

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Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

(N/A)
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed